STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155246	B. WIN			05/13/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				VERLY DR		
	OF DUNELAND, T				ERTON, IN46304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
		r a Recertification and	F0	000			
	State Licensure S	Survey. This visit					
	included the inve	estigation of complaint					
	IN00089829.						
	Complaint IN000	089829 unsubstantiated					
	due to a lack of e						
	Survey dates: Ma	ay 9, 10, 11, and 13, 2011					
	Facility number:	000150					
	Provider number						
	AIM number:	100267000					
	Alivi liuliloet.	100207000					
	C						
	Survey team:	DAY TO					
	Regina Sanders,						
	Sheila Sizemore,						
	Marcia Mital, RN	N (May 9, 2011)					
	Congue had tyma						
	Census bed type:						
	SNF/NF: 96						
	Total: 96						
	Census payor typ	ae.					
	Medicare: 16						
	Medicaid: 70						
	Other: 10						
	Total: 96	5					
	Sample:	20					
	•						
	Supplemental sar	inpie. I					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 000150

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155246	B. WING			05/13/2	011
			p. whice		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.			VERLY DR		
WATERS	OF DUNELAND, T	HE			ERTON, IN46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		es also reflect State					
	findings cited in	accordance with 410 IAC					
	16.2.						
	Quality review c	ompleted 5-16-11					
	Cathy Emswiller	-					
	5						
F0282		ided or arranged by the					
SS=D		ovided by qualified persons					
		n each resident's written					
	plan of care.		F02	202	Plan of Correction F282The		05/20/2011
		review, observation, and	F02	282	facility does provide qualified	ı	03/20/2011
		cility failed to follow			persons in accordance with e		
		rs related to a blood			residents written plan of care		
	•	tion and insulin for 2 of			The actions taken by the faci		
	20 residents revi	ewed for physician's			are as follows:Regarding R7	the	
	orders in a sampl	le of 20. (Residents #7			physician was notified on	o to	
	and #15)				5/11/2011 at 11AM in regards R7 not receiving PRN Clonid		
					as ordered. No new orders w		
	Findings include	:			received. On 5/16/2011 and		
	<i>O</i> 1 11.11				was received to discontinue	the	
	1 Resident #7's	record was reviewed on			PRN Clonidine.Regarding R		
		a.m. The resident's			the physician was notified on		
					5/12/2011 at 9:15AM in rega R15 receiving 2 units of Nove		
	_	ed, but were not limited			insulin instead of 3 units. No		
		and end stage renal			orders were received.II. The		
	disease.				facility's actions taken to ider	ntify	
					other residents are as	I	
	-	der, dated 04/26/11,			follows:100% review of all		
	indicated an orde				residents for PRN Clonidine reviewed by D.O.N No othe		
	(anti-hypertensiv	ve) 0.1 milligrams, twice a			residents had orders for PRN		
	day as needed for	r systolic (top number)			Clonidine.100% review of all		
	blood pressure m	nore than 150 and/or			residents receiving sliding so		
	•	ressure (bottom number)			insulin were reviewed by the		
	more than 90.	,			D.O.N No further issues we	re	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NVYY11 Facility ID:

000150

If continuation sheet

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li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155246	B. WIN	IG		05/13/2	011
NAME OF	PROVIDER OR SUPPLIER	- {	•		ADDRESS, CITY, STATE, ZIP CODE	-	
					VERLY DR		
WATERS	S OF DUNELAND, T	THE		CHEST	ERTON, IN46304		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					identified.III. The measures prints place by the facility are a		
	The Medication	Administration Record			follows. The licenced nursing		
	(MAR), dated 05	5/11, indicated the			were re-inserviced on followi		
	resident's blood	pressure was 163/98 at 9			physicians orders on 5/13/20		
	a.m. on May 2, 2	2011.			and 5/14/2011.The		
					D.O.N./designee will review a		
	The Medication	Administration Record,			new PRN Clonidine orders w received and review 3 times		
	dated 05/11, and	the Nurses' Notes, dated			week and as	u	
	05/02/11, lacked	documentation to			needed.The D.O.N./designee		
	indicate the resid				audit all residents with sliding	-	
	Clonidine as ord	ered by the physician.			scale insulin orders 3 times a		
		3 1 3			week and as needed.IV. The facility will moniter actions as		
	During an observ	vation on 05/10/11 at 11			follows:The D.O.N./designee		
	1 -	irector of Nursing present,			review any new PRN Clonidi	ne	
	1	an unopened box of			orders when received and re	view	
	Clonidine 0.1 mi	_			3 times a week and as		
	medication cart.	inigrams in the			needed.The D.O.N./designed audit all residents with sliding		
	inedication cart.				scale insulin orders 3 times a	•	
	Danin a an intama	: or 05/10/11 of 11			week and as needed.The au		
		iew on 05/10/11 at 11			will be reviewed in the Quart	•	
	1	or of Nursing indicated the			Quality Improvement Meeting		
		ot been given as ordered			Quality Improvement Commi will determine the end date for		
	for the high bloo	od pressure.			audits.	or title	
	a b						
		s record was reviewed on					
		0 a.m. The resident's					
	~	led, but were not limited					
	to, diabetes mell	itus and hypertension.					
	1	Recapitulation Orders,					
	1	icated an order for					
	1	to be given per the blood					
	sugar result (slid	ling scale), four times					
	daily. The order	indicated for a blood					
	sugar 151-200 to	give three units of					

OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
155246		A. BUIL	DING	00		
	100240	B. WINC		PRINCE OF THE COLUMN	03/13/2	011
ROVIDER OR SUPPLIER						
OF DUNELAND, T	HE					
			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
		1	I	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION DATE
	ESC IDENTIFY ING INFORMATION		IAG	,		DATE
msum.						
resident's blood s	ugar was 156 at 6 a.m.					
During an intervi	ew on 05/11/11 at 12:10					
-						
•						
	C					
3.1-35(g)(2)						
A resident who is a of daily living receit to maintain good in personal and oral library an	ves the necessary services putrition, grooming, and hygiene. ation, record review, and allity failed to ensure a suired assistance for taff assistance during a esidents who required a sample of 20 ent #10) sobserved on 5/09/11 at g in his bed with the ta 30 degree angle. His laced on the overbed	F03	312	receive the necessary service maintain good nutrition, grooming, and personal and hygine.I.The actions taken by facility are as follows:Regard R10. R10 expired on 5/10/11 The facility's action taken to identify other residents are as follows:All residents who nee assistance with meals while is bed were reviewed and no fur issues identified.III. The measures put into place are follows:Nursing staff was reinserviced on 5/13/2011 and	oral y the ing .II. s ed in urther	05/20/2011
	of DUNELAND, T SUMMARY S' (EACH DEFICIENCE REGULATORY OR INSUlin. The MAR, dated resident's blood son 05/01/11 and given at 7 a.m. During an interviry p.m., LPN #2 indinsulin should hat two units of insulin should have units of insulin should have units of insulin should have resident who requesting received simeal for 1 of 6 restaff assistance in residents. (Resident #10 was 12:16 p.m., layin head of the bed a noon meal was pinched.)	ROVIDER OR SUPPLIER OF DUNELAND, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) insulin. The MAR, dated 05/11, indicated the resident's blood sugar was 156 at 6 a.m. on 05/01/11 and two units of insulin was given at 7 a.m. During an interview on 05/11/11 at 12:10 p.m., LPN #2 indicated three units of insulin should have been given instead of two units of insulin.	ROVIDER OR SUPPLIER OF DUNELAND, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) insulin. The MAR, dated 05/11, indicated the resident's blood sugar was 156 at 6 a.m. on 05/01/11 and two units of insulin was given at 7 a.m. During an interview on 05/11/11 at 12:10 p.m., LPN #2 indicated three units of insulin should have been given instead of two units of insulin. 3.1-35(g)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview the facility failed to ensure a resident who required assistance for eating received staff assistance during a meal for 1 of 6 residents who required staff assistance in a sample of 20 residents. (Resident #10) Findings include: Resident #10 was observed on 5/09/11 at 12:16 p.m., laying in his bed with the head of the bed at a 30 degree angle. His noon meal was placed on the overbed	ROVIDER OR SUPPLIER OF DUNELAND, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Insulin. The MAR, dated 05/11, indicated the resident's blood sugar was 156 at 6 a.m. on 05/01/11 and two units of insulin was given at 7 a.m. During an interview on 05/11/11 at 12:10 p.m., LPN #2 indicated three units of insulin should have been given instead of two units of insulin. 3.1-35(g)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview the facility failed to ensure a resident who required assistance for eating received staff assistance during a meal for 1 of 6 residents who required staff assistance in a sample of 20 residents. (Resident #10) Findings include: Resident #10 was observed on 5/09/11 at 12:16 p.m., laying in his bed with the head of the bed at a 30 degree angle. His noon meal was placed on the overbed	ROVIDER OR SUPPLIER OF DUNELAND, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) insulin. The MAR, dated 05/11, indicated the resident's blood sugar was 156 at 6 a.m. on 05/01/11 and two units of insulin was given at 7 a.m. During an interview on 05/11/11 at 12:10 p.m., LPN #2 indicated three units of insulin should have been given instead of two units of insulin. 3.1-35(g)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview the facility failed to ensure a resident who required assistance for eating received staff assistance for eating received staff assistance during a meal for 1 of 6 residents who required staff assistance in a sample of 20 residents. (Resident #10) Findings include: Resident #10 was observed on 5/09/11 at 12:16 p.m., laying in his bed with the head of the bed at a 30 degree angle. His noon meal was placed on the overbed table which experieted the graved bears.	ROVIDER OR SUPPLIER OF DUNELAND, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Insulin. The MAR, dated 05/11, indicated the resident's blood sugar was 156 at 6 a.m. on 05/01/11 and two units of insulin was given at 7 a.m. During an interview on 05/11/11 at 12:10 p.m., LPN #2 indicated three units of insulin should have been given instead of two units of insulin. 3.1-35(g)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview the facility failed to ensure a resident who required staff assistance for eating received staff assistance for eating received staff assistance for eating received staff assistance for eating a meal for 1 of 6 residents who required staff assistance in a sample of 20 residents. (Resident #10) Findings include: Resident #10 was observed on 5/09/11 at 12:16 p.m., laying in his bed with the head of the bed at a 30 degree angle. His noon meal was placed on the overbed SIRRET ADDRESS, CITY, STATE, ZIP CODE THO SEVERLY DR CHESTERTON, IN46304 PROVIDERS PLANGE CORRECTION (EACH OF ACTION AND ADDRESS PLANGE CORRECTION (IN46304) PROVIDERS PLANGE CORRECTION (IN46304 PROVIDERS P

000150

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155246		LDING	00	05/13/2	
		100210	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF I	PROVIDER OR SUPPLIE	₹		1	VERLY DR		
WATERS	S OF DUNELAND, 1	THE		1	ERTON, IN46304		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	need the assistance.License	d	DATE
	1 0,	wberry shortcake. There s of mighty shakes			nursing staff will do daily rou		
		C 3			and document for all residen		
		ne had been opened and			who eat in bed for proper		
	_	our ounce glass. The other mained unopened. The			positioning and need for assistance for all meals.IV. T	he.	
	1 .	ottle of sweet tea in his			facility will monitor actions as		
					follows.Licensed nursing star	ff will	
	resident's room.	re no staff present in the			do daily rounds and docume		
	resident's foom.				all residents who eat in bed f proper positioning and need		
	Pagidant #10	s observed on 5/09/11 at			assistance with meals for all	101	
		0 p.m., 12:41 p.m., 12:50			meals. The audits will be		
	_				reviewed in the Quarterly Qu	ality	
	1	with no staff present in om. The resident's meal			Improvement Committee Meeting.The Quality Improve	mont	
					Committee wil determine the		
		ched by the resident. An			date for audits.		
		05 p.m., indicated the					
		ray had been removed					
	from the room.						
	During an interv	iew on 5/09/11 at 1:07					
	p.m., CNA #1 in	dicated She had taken the					
	resident's meal to	ray. She indicated she					
	had not fed the r	esident. She indicated					
	she did not work	the 100 hall. She					
	indicated she wa	s a hall monitor and was					
	answering call li	ghts. Observation of the					
	resident's meal to	ray in the food rack					
	indicated the res	ident's noon meal went					
	untouched.						
	During an interv	iew on 5/09/11 at 1:08					
	p.m., LPN #2 in	dicated the resident was					
	capable of feeding	ng himself. LPN #2					
	indicated the res	ident needed to be sitting					
	in an up right po	sition. LPN #2 indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155246	B. WIN			05/13/2	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	VERLY DR		
WATERS	S OF DUNELAND, 1	THE		1	ERTON, IN46304		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)		DATE
the resident "would only drink mighty							
	shakes and juice	."					
	During an interv	iew on 5/09/11 at 1:40					
	_	Director of Nursing)					
		ident was able to feed					
		N indicated the resident					
	should be sitting	up better.					
		ecord was reviewed on					
		a.m. Resident #10's					
	diagnoses includ	led, but were not limited					
	to, anorexia, adv	ranced malnutrition,					
	failure to thrive.	and dysphagia (difficulty					
	•	esident #10 was placed on					
	Hospice on 5/02	-					
	1103piec on 3/02	, 11.					
	A 1	DC (Minimum Data Cat)					
		DS (Minimum Data Set)					
	· ·	d 4/27/11, indicated					
		d short term memory					
	1 ~	as moderately impaired					
	for decision mak	ring. The admission					
	MDS assessmen	t indicated the resident					
	required extensive	ve one person assist for					
	eating.	1					
	A care plan for "	potential for aspiration r/t					
		• •					
	1 ' ' '	hagia delay in swallow					
	1	ar throat after swallow,"					
		dicated "Observe					
	ability when eati	ing. Assist with meals as					
	needed. Monito	r for s/s (signs and					
		ration elevated temp,					
		wing, adventitious lung					
	Lannearty Swano						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
		155246	B. WING		05/13/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN46304				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	Living), dated 4/ as needed" 3.1-38(a)(2)(D)	DLS (Activities of Daily 25/11, indicated "Assist					
F0315 SS=D	assessment, the firesident who enteresident who enteresident's clinical that catheterization resident who is incompropriate treatment urinary tract infect normal bladder for Based on observinterview, the fact catheter tubing we reduce the risk for residents with insample of 20 residents with insample of 2	ation, record review and cility failed to ensure a vas positioned correctly to or infection for 1 of 5 dwelling catheters in a idents reviewed for ters. (Resident #19)	F0315	Plan of Correction F315The facility does ensure that a resident who enters the facili without an indwelling cathete not catherized unless resider clinical condition demonstrat that catherization was neces and a resident who is inconti of bladder receives appropriateatment and services to pre UTI's and to restore as much normal bladder function possible.I.The actions taken the facility are as follows:Regarding R19. Fole catheter was corrected as so as surveyor brought it to the D.O.N.'s attention. Physician	er is ints es es esary: inient ate event in as by		

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/13/2	ETED	
	PROVIDER OR SUPPLIE S OF DUNELAND, SUMMARY		STREET A	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN46304		(X5)
PREFIX TAG	1	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAU	rehabilitation di staff. Resident #19 wa 11:20 a.m., and catheter tubing or rehabilitation di During an interva.m., the DoN (of indicated the cathon the floor. Resident #19's r 5/10/11 at 11:36 diagnoses include to, hypertension and dementia. The physician's indicated the residely catheter. A facility policy "Urinary Cathet Care," indicated on a daily basis system free of k maintain below	ning room being fed by as observed on 5/10/11 at 11:30 a.m., with her foley on the floor in the	IAU	notified on 5/17/2011 at 3:3 regarding foley catheter tub the floor. No new orders received.II. The facility's act identify other residents are follows:All residents with fol catheter were assessed for proper placement of foley catheter tubing. No further i identified.III. The measures into place by the facility are follows:Nursing staff was re-inserviced on 5/13/2011 5/14/2011 for proper placement of each tubing. Nursin will complete an audit daily 6:30AM to 8:30PM for proper placement of all residents with foley catheters.IV. The facil moniter actions as follows:Nursing staff will con and audit daily from 6:30AM 8:30PM for proper placement all residents with foley catheters. The audits will be reviewed in the Quarterly Quinprovement Committee Meeting. The Quality Improv. Committee will determine the date for audits.	ing on ion to as ey ssues put as and nent of g staff from er with ty will mplete I to ent of uality ement	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		A. BUILDING 00 CO		COMPL) DATE SURVEY COMPLETED 5/13/2011		
	PROVIDER OR SUPPLIER			110 BE\	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0323 SS=D	environment rema hazards as is poss receives adequate devices to prevent Based on observatinterview, the fact adequate supervitor 1 of 6 resident problems in a sar #10). Findings include: Resident #10 was 12:16 p.m., layin head of the bed a noon meal was ptable, which conshotdog, and straw were two cartons (supplement), on poured into a four mighty shake remained into a four mighty shake remained untouch the resident's room. Resident #10 was 12:31 p.m., 12:40 p.m., 12:55 p.m. the resident's room remained untouch	ation, record review, and cility failed to provide sion during meal times ts who had swallowing mple of 20. (Resident	F0	323	Plan of Correction F323The facility does ensure that the residents environment remain free of accident hazards and resident does receive adequate supervision and assistive development to prevent accidents. I. The actident by the facility are as follows: Regarding R10. R10 expired on 5/10/2011. II. The facility's action taken to ident other residents is as follows: residents who need assistant with meals wihile in bed were reviewed and no further issue identified. III. The measures printo place are as follows: Nursistaff was reinserviced for assistance with feeding resid in bed who need the assistant and for proper positioning on 5/13/2011 and 5/14/2011. Licensed nursing swill do daily rounds and document for proper positioning and the need for assistance with meals. IV. The facility will moractions as follows: Licensed nursing staff will do daily round document for proper positioning and the need for assistance with meals. The arm will be reviewed at the Quart Quality Improvement commit Meeting. The will determine the experience of account of the proper positioning and the reviewed at the Quart Quality Improvement commit Meeting. The Quality Improvement commit Meeting. The will determine the experience of account of the proper positioning and the reviewed at the Quart Quality Improvement commit Meeting. The Quality Improvement commit Meeting. The will determine the experience of account of the proper position of the proper po	each ate vices ction ify All ce es out sing ents nce staff ament e niter nds udit erly tee ement	05/20/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		A. BUII	LDING	nstruction 00	(X3) DATE S COMPL 05/13/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE /ERLY DR		-
WATERS	OF DUNELAND, T	HE		CHEST	ERTON, IN46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	resident's meal to from the room.	ray had been removed			date for audits.		
	p.m., CNA #1 in resident's meal to had not fed the reshed indicated she was answering call his resident's meal to indicated the resolution and intervent p.m., LPN #2 increased to be sitt position. During an intervent p.m., the DoN (I indicated the reshetter. Resident #10's reshed to, anorexia, advertile failure to thrive,	iew on 5/09/11 at 1:07 dicated She had taken the ray. She indicated she esident. She indicated the 100 hall. She is a hall monitor and ghts. Observation of the ray in the food rack ident's noon meal went iew on 5/09/11 at 1:08 dicated the resident ing up in a more upright iew on 5/09/11 at 1:40 Director of Nursing) ident should be sitting up in a.m. Resident #10's ed, but were not limited anced malnutrition, and dysphagia (difficulty esident #10 was placed on /11.					
		DS (Minimum Data Set) d 4/27/11, indicated					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155246	B. WIN			05/13/20	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				VERLY DR		
WATERS	OF DUNELAND, T	HE		I	ERTON, IN46304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		l short term memory					
	problems and wa	s moderately impaired					
	for decision mak	ing. The admission					
	MDS assessment	indicated the resident					
	required extensiv	ve one person assist for					
	eating.	1					
	-34						
	A care plan for "	potential for aspiration r/t					
		· -					
		nagia delay in swallow					
	_	ar throat after swallow,"					
	•	dicated "Observe					
		ng. Assist with meals as					
	needed. Monitor	for s/s (signs and					
	symptoms) aspira	ation elevated temp,					
	difficulty swallov	wing, adventitious lung					
	sounds"	2,					
	2 2 27-272111						
	Λ care plan for Λ	DLS (Activities of Daily					
	•	,					
		25/11, indicated "Assist					
	as needed"						
	•	ied barium swallow					
	evaluation report	(swallowing test), dated					
	4/29/11, indicate	d "Pt (patient) presents					
	with severe orop	hanyngeal dysphagia					
	_	reased airway protection					
	resulting in aspir						
	During an intervi	iew on 5/11/11 at 11:17					
	_						
	_	Therapist indicated the					
		e in an upright 90					
		osition when consuming					
	food and liquid.	The Speech Therapist					
	indicated there w	as a possibility of					
		L7			<u> </u>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN46304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	aspiration. A facility policy, dated 1/07, indic	titled "Eating Support," ated "Assist the per sitting position"						